MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

08600

Reg. Dist. No. 1

1. PLACE OF DEATH:

County: Allegany

City or town: Little Orleans

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 minutes

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Little Orleans

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME ~~Infant~~ Appel Kenneth Ray

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) August 14, 1947

8. AGE:

Years	Months	Days	If less than one day
—	—	—	— hrs. 40 min.

9. Birthplace: Little Orleans Allegany Co. Md.

(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER — 12. Name: Mason A. Appel

FATHER — 13. Birthplace: Allegany Co. Md.

MOTHER — 14. Maiden name: Julia E. Engle

MOTHER — 15. Birthplace: Cumberland, Md.

16. Informant: Mason A. Appel

Address: Little Orleans, Md.

17. Burial (Burial, cremation or removal. Which?) Date thereof Aug 15 1947 (month) (day) (year)

Cemetery or crematory: M. E. Cemetery

Location: Little Orleans, Md.

18. Funeral director: Edward Martin

Address: Little Orleans, Md.

19. 8/15/47 (Date rec'd by registrar) 19 Mrs L. A. Shawhelt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14 1947, at 8.40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 14 1947, to Aug 14 1947

and that I last saw h. alive on Aug 14 1947

Immediate cause of death	DURATION
Rickets	
Due to: Premature birth	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: J. A. Watson M. D. or other

Address: Little Orleans Md. Date signed 8/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

S-A15

06601

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 48 Linden St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 48 Linden

(If rural, give LOCATION)

2.(a) If veteran, name war: - - - - -

3.(a) FULL NAME: Sarah Griffith Beach

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John J. Beach

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 19, 1862

8. AGE:

Years	Months	Days	If less than one day
85	3	24	..... hrs. ..... min.

9. Birthplace: Blaenavon, Wales (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: - - -

FATHER

12. Name: David Griffith

13. Birthplace: Wales

MOTHER

14. Maiden name: Mary Yates

15. Birthplace: Wales

16. Informant: Mrs. Althea Henshaw

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 15 1947 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg, Md.

18. Funeral director: J. R. Hurst

Address: Frostburg Md.

19. 8-15 1947 (Date rec'd by registrar) Miss Hallie N. Rae Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/14 1947, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 8/12 1947, to ..... 19..

and that I last saw her alive on 8/12 1947

Immediate cause of death	DURATION
Arteriosclerotic Heart Disease	10 yrs
Due to: generalized arteriosclerosis	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank T. Harrat M.D. M. D. or other

Address: 522 E. Main St. Frostburg Md. Date signed: 8/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06603

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, Institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Bloomington, near Frostburg (If outside city or town limits, write RURAL and give nearest town)
Street No. — (If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Jacob J. Bittinger

3.(b) Social Security Number: —

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Elizabeth Hoover
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Nov. 12, 1872

8. AGE: Years: 74 | Months: 9 | Days: 7 | If less than one day: ... hrs. ... min.

9. Birthplace: Jennings, Garrett Co., Md. (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business: Farming
12. Name of father: Jacob Bittinger
13. Birthplace of father: Garrett Co. Md.
14. Maiden name of mother: Frazenbaker
15. Birthplace of mother: Lenoxville
16. Informant: Raymond Bittinger
Address: Lonaconing, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 21, 1947 (month) (day) (year)
Cemetery or crematory: Laurel Hill Cemetery
Location: Roscoe, Md.
18. Funeral director: H. L. Eichhorn
Address: Maryland
19. 8-20-1947 (Date rec'd by registrar) Mrs. Nancy N. Roe, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 19, 1947, at 9:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 12, 1947, to Aug 19, 1947, and that I last saw him alive on Aug 19, 1947

Immediate cause of death	DURATION
Intestinal Obstruction	36 hrs
Due to: Pelvic abscess	1 week
Due to: Propelle sustained Appendectomy	10 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Pelvic Abscess, Intestinal Obstruction. Date of op. Aug 19, 1947
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. O. McLane Jr. M.D. (M. D. or other)
Address: Frostburg, Md. Date signed: 8-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

06604

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County Allegany
City or town Lonaconing (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 82 years
Hospital, Institution, or street address where death occurred: Robbins Street
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Allegany
City or town Lonaconing (If outside city or town limits, write RURAL and give nearest town)
Street No. Robbins (If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Martha E. Metz Bradley

3.(b) Social Security Number —

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: John Bradley
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): July 31, 1859
8. AGE: Years 88 Months — Days 20 If less than one day ... hrs. ... min.
9. Birthplace: Pekin, Allegany Co., Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own Home
FATHER 12. Name: Metz
FATHER 13. Birthplace: Unknown
MOTHER 14. Maiden name: "
MOTHER 15. Birthplace: "
16. Informant: Joseph Bradley
Address: Lonaconing, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 24 1947 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing, Md.
18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.
19. 8-24 1947 (Date rec'd by registrar) Johnette M. Bond Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/21/47 at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 8/12 1947 to 8/21 1947 and that I last saw h[illegible] alive on 8/17/47

Immediate cause of death	DURATION
Congestive Heart failure	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Paul Eugene Dreyer M. D. or other
Address Lonaconing, Md. Date signed 8/23/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157e

06602

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 108 Harrison St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Terry Wayne Britt

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 13, 1947

8. AGE: Years	Months	Days	If less than one day
0	0	3	..... hrs. ..... min.

9. Birthplace Cumberland, Allegany, Md.

(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER

12. Name Otis W. Britt

13. Birthplace Grantsville, Md.

MOTHER

14. Maiden name Fawn B. Sturtz

15. Birthplace Frostburg, Md.

16. Informant Otis W. Britt

Address 108 Harrison St, Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 18, 1947 (Month) (day) (year)

Cemetery or crematory Zion Memorial Park

Location Cumberland, Md.

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. Aug. 18, 1947 (Date rec'd by registrar) Lorrie R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1947, at 5:37 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 Aug 1947 to 16 Aug 1947 and that I last saw h alive on 16 Aug 1947

Immediate cause of death	DURATION
Congenital Heart.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dallas B Hartwart M. D. or other

Address 112 Bedford St. Date signed 17 Aug 47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06603 McLane

73a

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 157 Wood St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 157 Wood

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Jeanette Brode

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife: Andrew Brode

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 19-1867

8. AGE: Years	Months	Days	If less than one day
80	3	11	hrs. min.

9. Birthplace: Penna. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER — 12. Name: Wm. Hill

13. Birthplace: Ireland

MOTHER — 14. Maiden name: Mary Johnson

15. Birthplace: Ireland

16. Informant: Mrs Walter Thayer

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 12-1947 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg Md.

18. Funeral director: J J Dunn

Address: Frostburg, Md.

19. 9-2 (Date rec'd by registrar) 1947 Mrs. Hadley N. Rae Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 30 1947 at 630 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 1946 to Aug 30 1947 and that I last saw her alive on Aug 26 1947

Immediate cause of death	DURATION
Pernicious Anaemia	2 yrs
Due to	
Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W D McLane M.D. M. D. or other

Address: Frostburg Md. Date signed: Sept 2 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

DR. W. F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a 8

06606

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days.
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 7 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State PENNSYLVANIA County BEDFORD
City or town LAKE GORDON (If outside city or town limits, write RURAL and give nearest town)
Street No. ROUTE #3 LAKE GORDON Road
CUMBERLAND MD.
2.(a) If veteran, name war

3.(a) FULL NAME MR. CHARLES J. BRUCE

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	Widowed

6.(b) Name of husband or wife MAUD WOLFF
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) OCTOBER 31, 1878

8. AGE: Years	Months	Days	If less than one day
68	9	8	..... hrs. ..... min.

9. Birthplace PICTOU, NOVA SCOTIA (Town, county, and state or foreign country)
10. Usual occupation SUPT. OF [redacted] CREEK WATER CO.
11. Industry or business

FATHER
12. Name WILLIAM THOMAS BRUCE
13. Birthplace NOVA SCOTIA

MOTHER
14. Maiden name MARY AL ICE ~~STRATON~~ Stratton
15. Birthplace SCOTLAND

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MARYLAND

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof AUG 12, '47 (month) (day) (year)
Cemetery or crematory Fellowship Cem.
Location Cumberland Valley Pa.
18. Funeral director LOUIS STEIN INC.
Address CUMBERLAND Md.

19. Aug 11 1947 (Date rec'd by registrar) Writes R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 9, 1947, at 7:40 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 8-1-47 to 8-9-47
and that I last saw h[redacted] alive on 8-9-47

Immediate cause of death	DURATION
Pneumonia	8 days
Due to Thrombosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE W. F. Williams M. D. or other
Address Cumberland Date signed 8/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C

06607

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 1/1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residences of mother)

State: Md. County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 210 Wallace St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: John Enlow T. Callahan

3.(b) Social Security Number: 214-05-8229

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Gertrude H. McVicker

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 22-1889

8. AGE: Years	Months	Days	If less than one day
58	3	7	____ hrs. ____ min.

9. Birthplace: Salem, Ohio (Town, county, and state)

10. Usual occupation: Sales Manager for the Co.

11. Industry or business: Tri-State Mine & Mill Supply

FATHER — 12. Name: John Callahan

FATHER — 13. Birthplace: Ohio

MOTHER — 14. Maiden name: Adelaide Tenchs

MOTHER — 15. Birthplace: Ohio

16. Informant: Gertrude Callahan

Address: 210 Wallace St, Cumberland, Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept. 1, 1947 (month) (day) (year)

Cemetery or crematory: Hillcrest Burial Park

Location: Cumberland Md

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19. Sept 1 1947 (Date rec'd by registrar) Hunter A. Grantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 29 1947 at 4.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__ to ____ 19__ and that I last saw him Dead Aug. 29 1947

Immediate cause of death	DURATION
Coronary thrombous of the right coronary artery.	about 1 1/2 hours
***Cardiac hypertrophy	
Due to: Sclerosis of the left coronary artery.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D. or other

Address: Cumberland Md. Date signed: 8/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Outside of City Limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 115 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06608

93e

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Near Cumberland, Rural (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 Years

Hospital, institution, or street address where death occurred: Rt 4, Oldtown Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Near Cumberland, Rural (If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt 4, Oldtown Road (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary Susan Carder

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Lafayette A. Carder

6.(c) If alive, give age: 83 years

7. Birth date of deceased (mo., day, yr.): April 5 1868

8. AGE: Years: 79 Months: 4 Days: 12 If less than one day ... hrs. ... min.

9. Birthplace: Romney, Hampshire Co, West Virginia (Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER

12. Name: Alexander Sanders

13. Birthplace: Rowlesburg, Pa.

MOTHER

14. Maiden name: Mary Ann Hannas

15. Birthplace: Shanks, W. Va.

16. Informant: Mrs. Lester Mullenax

Address: Rt 4, Oldtown Rd, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/20/47 (month) (day) (year)

Cemetery or crematory: Ebenezer Cemetery

Location: Romney, W. Va.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Aug 18 1947 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17 1947, at 6-40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1947, to Aug. 17, 1947

and that I last saw her alive on Aug. 15, 1947

	DURATION
Immediate cause of death: Myocarditis	6 mo
Due to: Generalized Arteriosclerosis	6 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Alonzo E. Everett M.D. or other

Address: Cumberland Date signed: Aug. 17, 1947

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

06699

Reg. Diat. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs.

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 12 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 119 Cumberland St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Calvin Clingston

3.(b) Social Security Number 214-07-0501

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Elizabeth Preasmann 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 28 1880

8. AGE: Years	Months	Days	If less than one day
67	-	27	..... hrs. ..... min.

9. Birthplace Hancock Md. (Town, county, and state)

10. Usual occupation Salesman

11. Industry or business U.S. Tire Co

FATHER 12. Name Fred Clingston

13. Birthplace Ind

MOTHER 14. Maiden name Unknown.

15. Birthplace

16. Informant Miss Wanda Clingston

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 27 47 (month) (day) (year)

Cemetery or crematory German Benificial Cem

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Aug. 27, 1947 (Date rec'd by registrar) Witter R. Krantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1947, at 4:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1947 to Aug 25 1947 and that I last saw him alive Aug 24 1947 Dead

Immediate cause of death	DURATION
Chronic nephritis	several years
Due to	
Due to	
Other conditions Nephritis, Chronic	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H. V. Deming M.D. M. D. or other

Address Cumberland Md. Date signed 8/25/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92 b

06610

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

Street No.: St. Mary's Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Martha J. Miller Coleman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: August Coleman

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 10, 1869

8. AGE: Years: 78 | Months: 1 | Days: 12 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Barton Allegany Co., Md.
(Town, county and state)

10. Usual occupation: Housekeeper

11. Industry or business: Own home.

FATHER
12. Name: Christopher C. Miller
13. Birthplace: Maryland

MOTHER
14. Maiden name: Jane Warwick
15. Birthplace: Unknown

16. Informant: Mrs. Ada Coleman Gardner

Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 25, 1947 (month) (day) (year)

Cemetery or crematory: Laurel Hill Cemetery

Location: Moscow, Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. Aug 24, 1947 (Date rec'd by registrar) Walter R. Frantz, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 22 1947, at 10 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 19, 1947 to Aug 22 1947

and that I last saw h[illegible] alive on Aug 22 1947

Immediate cause of death	DURATION
Cerebral Embolus (left side)	1 day
Due to	
Due to 92 b	
Major Conditions Pulmonary Edema	?
Other conditions Diabetes 1142	?

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op.: ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Samuel Jacobs M. D. or other

Address: 50 Penn Ave Cumb Md Date signed: Aug 31 47

VS-A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

06611

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, institution or street address where death occurred: Allegany Hospital

How long in hospital or institution? 1 Yr Mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 514 Shriver Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: 1st World War

3. (a) FULL NAME: Charles Henry Colgate

3. (b) Social Security Number: 214-05-4928

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bernice Bowden

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 10 1885

8. AGE:

Years	Months	Days	If less than one day
61	8	8	..... hrs. ..... min.

9. Birthplace: Hopus Ferry W. Va. (Town, county, and state)

10. Usual occupation: Cashier

11. Industry or business: Brewery.

FATHER

12. Name: Ed A Colgate

13. Birthplace: Md.

MOTHER

14. Maiden name: Clara M. Lenox

15. Birthplace: W. Va.

16. Informant: Mrs Bernice Bowden Colgate

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 20 '47 (month) (day) (year)

Cemetery or crematory: Pleasant Grove Cem.

Location: Rural Cumberland Md

18. Funeral director: Harris Stein Inc

Address: Cumberland

19. Aug 20 1947 (Date rec'd by registrar) Winter R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18 1947, at 12 30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/15/46 19.. to 8/15/47 19.. and that I last saw him alive on 8/18/47 19..

Immediate cause of death	DURATION
Coronary Thrombosis	12 hrs
Due to: Coronary Sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. D. Williams M.D. M.D. or other

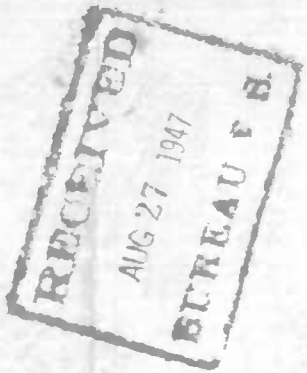
Address: Med Bldg, Cumb Md Date signed: 8/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr Richard
Williams



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

169

06612

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Died in ambulance on way to Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Rural) Mexico Farm R.F.D.# 4.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Near Cumberland, Rural
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ralph Cecil Collins

3.(b) Social Security Number 220-10-2028

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Elmira Long Collins

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 8-1901

8. AGE: Years	Months	Days	If less than one day
46	6	21	..... hrs. ..... min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Laboror

11. Industry or business

FATHER 12. Name George Collins Sr.

13. Birthplace Chaneysville Pa.

MOTHER 14. Maiden name Emma Weber

15. Birthplace Clear Spring Md.

16. Informant Mr. George W. Collins

Address R.D. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 1, 1947 (month) (day) (year)

Cemetery or crematory Mt. Herman Cem.

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. Sept 1 1947 (Date rec'd by registrar) Minta R. Trout, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29 19 47 at 1.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive Dead Aug. 29 19 47

Immediate cause of death	DURATION
Intracranial Hemorrhage due to	about
a depressed fracture of the	35
Due to right parietal bone	minutes
Due to	
Other conditions Fracture of the right clavicle	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 8-29-47

Where did injury occur? near Walton Tunnel (City or town) Mineral (County) W.Va. (State)

Injured at home, farm, industry, public place (where?) W. Md. R.Ry

Means of injury Struck by Train #2 Injured at work? Trespasser

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D. or other

Address Cumberland, Md. Date signed 8/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06613

174

Reg. Diat. No. 8

1. PLACE OF DEATH:

County Allegany

City or town Lonaconing Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4 Dudley St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles Carlyle Connor

3. (b) Social Security Number 216-07-2768

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Mary V. Elkins Connor

6.(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Nov. 10. 1906

8. AGE:	Years	Months	Days	If less than one day
	41	8	21	hrs. min.

9. Birthplace Lonaconing Md.
(Town, county, and state)

10. Usual occupation Miner

11. Industry or business Coal mining

FATHER
12. Name Edwards Thos. Connor
13. Birthplace Eckhart, Md

MOTHER
14. Maiden name Anna M. Hausman
15. Birthplace Pennsylvania

16. Informant Henry Connor
Address Lonaconing Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 4 1947 (month) (day) (year)

Cemetery or crematory allegany Cemetery

Location Frostburg

18. Funeral director M. Elichhorn

Address Lonaconing Md

19. 8/7 1947 (Date rec'd by registrar) Jaynetlem Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 1 1947 at 9.15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw him alive on Dead Aug. 1 1947

Immediate cause of death	DURATION
Suffocation	at once
Due to Covered by a fall of coal.	
Due to	
Other conditions Fractured 9 &10 ribs right side of chest	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 8-1-47

Where did injury occur? Lonaconing (City or town) Allegany (County) Md. (State) Mine

Injured at home, farm, industry, public place (where?) In Old Jackson

Means of injury Fall of roof coal Injured at work? yes

Deputy Medical Examiner - Allegany Co

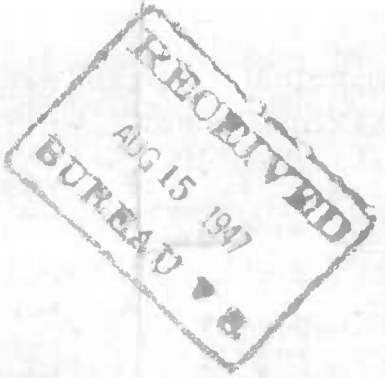
23. SIGNATURE H.V.Deming M.D. H.V. Deming M.D. M. D. or other

Address Cumberland Md Date signed 8-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
AUG 15 1947
BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06614

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40yrs

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 1 hr. & 50 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 425 Independence St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Charles W. Cox

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widowed.

6.(b) Name of husband or wife: Julia Long

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Nov. 10- 1881

8. AGE: Years	Months	Days	If less than one day
65	8	~~25~~ 27	____ hrs. ____ min.

9. Birthplace: Springfield W.Va.
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: City Street Dept

FATHER
12. Name: Thomas Cox
13. Birthplace: W.Va.

MOTHER
14. Maiden name: Rebecca Kaylor
15. Birthplace: W.Va.

16. Informant: Kirk Beckwith.
Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 9. 47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland.

19. Aug. 8 1947 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 7 19 47, at 3.30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____ and that I last saw him alive Dead Aug. 7 19 47

Immediate cause of death	DURATION
Coronary occlusion	at once
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. H. V. Deming
M. D. or other

Address: Cumberland Md. Date signed: 8-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

06615

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

125 b

DR. HODGES & DR. COOPER

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town Near CUMBERLAND, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. #1, Homewood Addt.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
MRS. BEARL CROSTEN

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife HOWARD CROSTEN
6.(c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) JAN. 9, 1913

8. AGE: Years	Months	Days	If less than one day
34	7	16	..... hrs. ..... min.

9. Birthplace WEST VIRGINIA (Town, County, and State)
10. Usual occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name DYE, Oliver
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden name COLLMAN, MYRTIE
15. Birthplace WEST VIRGINIA

16. Informant Howard H. Crosten
Address Rt. 1, Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 28 1947 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Cumberland, Md.

18. Funeral director John J. Hofer
Address Cumberland, Md.

19. Aug. 28 1947 (Date rec'd by registrar) Winter L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 25, 1947 at 3:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 1947 to Aug. 25 1947 and that I last saw h[illegible] alive on Aug. 25 1947

Immediate cause of death	DURATION
Anemia	
Due to Auricular fibrillation	
Due to Passive congestion of liver	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? .....

23. SIGNATURE W. T. Hodges, M.D.
M. D. or other
Address Cumberland, Md. Date signed 8/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 9-45-15M

Dr Diehl

06616

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 weeks
Hospital, Institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Centennial St. ext.
(If rural, give LOCATION)
2.(a) If veteran, name war: 1st World War

3.(a) FULL NAME: Orville Price Crowe

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Leota Crowe
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): January 5 1894

8. AGE: Years 53 | Months 7 | Days 12 | If less than one day: ...hrs. ...min.

9. Birthplace: Finzel Garrett Maryland (Town, county, and state)

10. Usual occupation: retired farmer

11. Industry or business:

FATHER
12. Name: John L. Crowe
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ida Ravenscraft
15. Birthplace: Maryland

16. Informant: Mrs. Leota Crowe
Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 19 1947 (month) (day) (year)
Cemetery or crematory: Mt. Brow Cemetery
Location: Garrett County

18. Funeral director: J. R. Durst
Address: Frostburg Md.

19. 8-18 1947 (Date rec'd by registrar) Iris Davey K. Rae Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17 1947, at 3:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1947, to August 17 1947
and that I last saw him alive on August 17 1947.

Immediate cause of death: Coronary occlusion — DURATION: 1 month
Due to: Chronic nephritis; diabetes mellitus
Due to: Bronchial asthma
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: X Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: X Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. C. Diehl, M.D.
M. D. or other
Address: Frostburg, Md. Date signed: 8/18/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

06617

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 Years

Hospital, Institution, or street address where death occurred:
517 Eastern Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 517 Eastern Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Marietta Dawson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Upton E. Dawson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 12 1866

8. AGE: Years	Months	Days	If less than one day
81	1	18	..... hrs. ..... min.

9. Birthplace: Bedford Valley, Bedford Co, Penna
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER
12. Name: William Whipp
13. Birthplace: Bedford Valley, Pa.

MOTHER
14. Maiden name: Martha Smith
15. Birthplace: Bedford Valley, Pa.

16. Informant: Miss Sarah Dawson

Address: 516 Marietta St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 3 1947 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Sept. 3 1947 (Date rec'd by registrar) Witter R. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 30 1947, at One A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Acute Indigestion (a) DURATION

Due to: Sour Eggs in diet (b)

Due to: (c)

Other conditions: Myocardial degeneration

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Keyser M. D. or other

Address: 122 Bedford St Date signed: 9/2/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A17 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06618

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 Years

Hospital, Institution, or street address where death occurred:

25 North Waverly Terrace

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 25 North Waverly Terrace

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ada Defibaugh

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Chenoweth Defibaugh

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 19 1858

8. AGE: Years	Months	Days	If less than one day
~~88~~ 88	~~7~~ 10	2	..... hrs. ..... min.

9. Birthplace: Bedford Bedford Co, Penna (Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER 12. Name: Jonathan Brighthill

FATHER 13. Birthplace: Bedford, Pa.

MOTHER 14. Maiden name: Margaret McKinley

MOTHER 15. Birthplace: Bedford, Pa.

16. Informant: Jeremiah T. Defibaugh

Address: 200 Glenn St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/24/47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Aug. 24, 1947 (Date rec'd by registrar) Writes R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 21 1947, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1947 to Aug 21 1947 and that I last saw her alive on Aug 20 1947

Immediate cause of death	DURATION
Chronic Myocarditis	18 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. A. Trowski Jr, M.D. M. D. or other

Address: Cumberland, Md Date signed Aug 22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
On the south side of Will's mountain inthe Narrows.
How long in hospital or institution? about 7 months.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Pa. County Sommerset
City or town Meyersdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 229 Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war 2 World War.

3.(a) FULL NAME William Christian Dia

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 15, 1923

8. AGE: Years 24 | Months 6 | Days 13? | If less than one day: hrs. min.

9. Birthplace Meyersdale, Pennsylvania (Town, county, and state)

10. Usual occupation Shoe Store Mgr.

11. Industry or business Own Business

FATHER 12. Name [redacted] Dia William Charles

13. Birthplace Germany

MOTHER 14. Maiden name Edna Baldwin

15. Birthplace Meyersdale Pa.

16. Informant Konhaus Funeral Home

Address Meyersdale, Penna.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 18, 1948 (month) (day) (year)

Cemetery or crematory Meyersdale Union Cemetary

Location Meyersdale Penna

18. Funeral director John J. Hafer

Address 230 Baltimore Cumberland

19 March 16, 19 48 (Date rec'd by registrar) W.R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH about Aug. 28 19 47 at ? M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... and that I last saw him alive on March 15 19 48

Immediate cause of death Starvation, shock & exposure — DURATION several days

Due to Fracture of 1st. lumbar vertebrae, sacrum & right ischum

Due to a fall on rocks on Mt. side

Other conditions paralysis of lower limbs.

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: about

Accident, suicide, or homicide accident Date of 8-23-47

Where did injury occur? Near Cumberland (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) South side of Will's mountain

Means of injury Fell on rocks Injured at work? no

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D. or other

Address Cumberland Md. Date signed 3-15-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

In corporate limits

DR. JACOBSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06619

Reg. Dist. No. 4

1. PLACE OF DEATH.
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 YRS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 208 THIRD STREET
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME
MRS. CLEMENTINE DiAGUSTINE

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife FRANK DiAgustine
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) FEB. 12 1894

8. AGE: Years	Months	Days	If less than one day
53	5	25	..... hrs. ..... min.

9. Birthplace ITALY
(Town, county, and state)
10. Usual occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name ENDICO Di CHICCO
13. Birthplace ITALY

MOTHER
14. Maiden name ANTONetta Serrafine
15. Birthplace ITALY

16. Informant FRANK DiAgustine
Address Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 9 47 (month) (day) (year)
Cemetery or crematory St. Mary's Cem.
Location Cumberland.

18. Funeral director Louis Stein Inc
Address Cumberland.

19. Aug 8 1947 (Date rec'd by registrar) Wistar R. Krantz, M Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 7, 1947 at 2:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 5 1947 to Aug 7 1947 and that I last saw her alive on Aug 6 1947

Immediate cause of death	DURATION
Acute Myocardial Failure	2 days.
Due to Coronary Artery Thrombosis	?
Due to	
Other conditions Cirrhosis of Liver	?
Large Post-op Ventral Hernia	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Samuel Jacobson M.D.
M. D. or other
Address 50 Pershing St. Date signed 8/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

06620

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 61 yrs. - 1 - 7

Hospital, institution, or street address where death occurred:

616 Washington St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 616 Washington St.

(If rural, give LOCATION)

2.(a) If veteran, name war: 1st World War

3.(a) FULL NAME: Arthur P. Dixon

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ellen Daisy

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): June 30 1886

8. AGE:

Years	Months	Days	If less than one day
61	1	5	... hrs. ... min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Dentist

11. Industry or business:

FATHER

12. Name: Charles T Dixon

13. Birthplace: Md.

MOTHER

14. Maiden name: Mary Miller

15. Birthplace: Md.

16. Informant: Mrs Frederick Steidmann

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 7 '47 (month) (day) (year)

Cemetery or crematory: Fallevest Cem

Location: Cumberland Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland.

19. Aug 7 19 47 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5 19 47, at 7 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Jan 19 47, to 5 Aug 19 47

and that I last saw h... alive on 5 Aug 19 47

Immediate cause of death: Coronary Heart Disease — DURATION: 11 Mos.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: W. Alfred Von Deme M. D. or other

Address: Cumberland, Md. Date signed: 6 Aug. 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

Within corporate l...

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

DR.W.F.WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46

CERTIFICATE OF DEATH

06621

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)
Street No. 209 FAYETTE (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME MRS.SALLY DOBBIE

3. (b) Social Security Number None

4. Sex: FEMALE
5. Color or race: WHITE
6.(a) Single, married, widowed, or divorced: WIDOWED
6.(b) Name of husband or wife: JAMES DOBBIE
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) JULY 19 1864
8. AGE: Years 83 Months — Days 18 If less than one day ... hrs. ... min.
9. Birthplace MD. (Town, county, and state)
10. Usual occupation HOUSE WORK
11. Industry or business AT HOME
FATHER 12. Name ANDREW JACKSON CLARK
13. Birthplace MARYLAND
MOTHER 14. Maiden name REBECCA CRESAP
15. Birthplace MARYLAND
16. Informant Mrs John F Sommerville
Address Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 9 47 (month) (day) (year)
Cemetery or crematory Rose Hill Cem
Location Cumberland
18. Funeral director Louis Stein Inc
Address Cumberland
19 Aug. 8, 19 47 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 7,1947 19... at 5;55 A.M. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 19 47, to August 7, 19 47
and that I last saw her alive on August 6, 19 47
Immediate cause of death Abdominal Carcinomatosis — DURATION: Several Months
Due to Parent growth aimed to big...ater Curvature
Due to Stomach
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations No Operation Cause in Lone
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE C H Hawkins M. D. or other
Address
Date signed 8-7 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131 a

06622

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs.

Hospital, institution, or street address where death occurred: Miners Memorial

How long in hospital or institution? 14 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Eckhart

(If outside city or town limits, write RURAL and give nearest town)

Street No. (R.F.D. No.): Frostburg, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Wm. Edgar Drew

3.(b) Social Security Number: 213-05-7091

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Jane Thomas

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Sept. 14th 1889

8. AGE:

Years	Months	Days	If less than one day
57	11	5	..... hrs. ..... min.

9. Birthplace: Middlethian, Allegany, Md. (Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business: Automobile

FATHER 12. Name: Edgar Drew

FATHER 13. Birthplace: Pennsylvania

MOTHER 14. Maiden name: Amelia Smith

MOTHER 15. Birthplace: England

16. Informant: Samuel T. Drew

Address: 921 Md. Ave. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 23rd 1947 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: Jacob Baker

Address: Frostburg, Md.

19. 8-20 1947 (Date rec'd by registrar) Mrs. Nancy V. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19 1947 at 8:50 A.M. E.S.T.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 19 1947 to August 19 1947 and that I last saw h.../I.../M.../alive on August 18 1947

Immediate cause of death	DURATION
C-V-R disease	1 yr.
Due to: with Uremia	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. D. Gattens M.D. M. D. or other

Address: Frostburg, Md. Date signed: 8/19/47

Within corporate limits

Dr. Schindler 06623

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 61-7-16

Hospital, Institution or street address where death occurred: 940 Glenwood St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 940 Glenwood St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Walter Everly

3.(b) Social Security Number: 214-05-4962

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Lottie Crumpis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 15 1886

8. AGE: Years: 61 Months: 7 Days: 16 If less than one day: ..... hrs. ..... min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: Trucker.

11. Industry or business: Brewery

FATHER 12. Name: Jerry M. Everly.

FATHER 13. Birthplace: Md.

MOTHER 14. Maiden name: Anna Mc Knew.

MOTHER 15. Birthplace: Md.

16. Informant: Lottie C. Everly.

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 3 47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland.

19. Sept. 3 1947 (Date rec'd by registrar) Walter R. Trask M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 31 1947, at 3 45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1946 to August 31 1947 and that I last saw him alive on August 31 1947.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 hour,
Due to: Hypertension C.V.D. Arteriosclerosis	years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: B. M. Schindler M.D. M. D. or other

Address: 41 Greene St Date signed: Sept. 2 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

163D

06624

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Memorial Hospital
How long in hospital or Institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 905 Virginia Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: W W II

3.(a) FULL NAME: John W. Foreman

3.(b) Social Security Number: 216-18-1146

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 4 1925

8. AGE: Years	Months	Days	If less than one day
22	5	6	hrs. min.

9. Birthplace: Cumberland Md (Town, county, and state)
10. Usual occupation: Celanese Corp. of Am.
11. Industry or business: Services Dept.

FATHER
12. Name: John W. Foreman
13. Birthplace: W.Va

MOTHER
14. Maiden name: Anna May Donius
15. Birthplace: Md.

16. Informant: John W. Foreman
Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 13, 1947 (month) (day) (year)
Cemetery or crematory: Hillcrest Cem
Location: Cumberland, Md
18. Funeral director: John J. Hafer
Address: Cumberland, Md.

19. Aug. 12, 1947 (Date rec'd by registrar) Walter L. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 10 19 47 at 6.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...
and that I last saw him alive Dead Aug. 10 19 47

Immediate cause of death	Duration
Uremia due to anuria due to	about 8 days
Bichloride of Mercury poisoning	
Due to	
Due to	
Other conditions: Endocarditis	
Ulceration of the colon	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Suicide August 10, 1947
Accident, suicide, or homicide: Under investigation (Suicide or homicide) Date of injury
Where did injury occur? Cumberland, Alleg. Co., Md. (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?): ?
Means of injury: Bichloride of Mercury poisoning Injured at work? No
Deputy Medical Examiner - Allegany Co

23. SIGNATURE: H.V. Deming M.D. H.V. Deming M.D. M. D. or other
Address: Cumberland Md Date signed: 8/12/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06625

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 322 Bedford St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 322 Bedford St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Grace Mattingly Frantz.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Ralph W. Frantz
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 12 1885

8. AGE: Years	Months	Days	If less than one day
61	9	21	hrs. min.

9. Birthplace: Cumberland Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: at Home.

FATHER
12. Name: Alexander B. Mattingly
13. Birthplace: Md.

MOTHER
14. Maiden name: Laura Anderson
15. Birthplace: Md.

16. Informant: Ralph W Frantz
Address: 322 Bedford St, Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 6 47 (month) (day) (year)
Cemetery or crematory: Hillcrest Burial Park
Location: Cumberland, Md.

18. Funeral director: Lonis Stein Inc
Address: Cumberland,

19. August 6, 19 47 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 3 19 47, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 19 47, to August 3 19 47 and that I last saw h[er] alive on August 3 19 47

Immediate cause of death	DURATION
Heart failure - left ventricular failure	24 h.
Due to: Arteriosclerotic heart disease Coronary occlusion & myocardial	10 years
Due to: operation	3 Days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Harold G. Wiseman M.D.
M. D. or other
Address: 122 Bedford St, Cumberland Date signed: Aug 4, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46a 8

06626

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: WEST VIRGINIA County: MINERAL
City or town: KEYSER
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: LORENZO GAITER

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	COLORED	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): — — 1870

8. AGE: Years	Months	Days	If less than one day
77			..... hrs. ..... min.

9. Birthplace: WEST VIRGINIA (Town, county, and state)

10. Usual occupation: RETIRED

11. Industry or business

FATHER — 12. Name: JACOB GAITER
13. Birthplace: WEST VIRGINIA

MOTHER — 14. Maiden name: ANN MARIAH WILSON
15. Birthplace: WEST VIRGINIA

18. Informant: Memorial Hospital
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 18-47 (month) (day) (year)
Cemetery or crematory: Green Cemetery
Location: Petersburg, W. Va.

18. Funeral director: W. Harold Fredericks
Address: Piedmont, W. Va.

19. Aug 18 1947 (Date rec'd by registrar) Wm. A. Getz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUGUST 16, 1947 1;20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26 1947 to 8-16- 1947
and that I last saw him alive on 8-16- 1947

Immediate cause of death: Carcinoma esophagus — DURATION: ?
Due to:
Due to:
Other conditions: Liver metastases
(Include pregnancy within 3 months of death)

Major findings of operations: no operation — Date of op.
Autopsy results: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Howard L. Tolson M.D.
Address: Cumberland, Md. M.D. or other — Date signed 8-18-47

Within corporate limits

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06627

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, institution, or street address where death occurred:
(sidewalk) Cor. So. Smallwood & Beall St.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 420 South Allegany St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Herbert Gaither

3.(b) Social Security Number: 705-10-6075

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife: Celia Taylor

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 7 1871

8. AGE: Years	Months	Days	If less than one day
75	9	17	..... hrs. ..... min.

9. Birthplace: Darlington, Maryland
(Town, county, and state)

10. Usual occupation: retired

11. Industry or business: Western Md. Railroad

FATHER 12. Name: John Gaither

FATHER 13. Birthplace: Baltimore, Md

MOTHER 14. Maiden name: Mary Bunting

MOTHER 15. Birthplace: unknown

16. Informant: Wilbur R. Gaither

Address: 420 S. Allegany St. Cumberland Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof August 16, 1947 (month) (day) (year)

Cemetery or crematory: Darlington Cemetery

Location: Darlington, Maryland

18. Funeral director: Louis Stein, Inc

Address: Cumberland, Md

19 Aug. 16 (Date rec'd by registrar) 19 47 Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 13 19 47, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... im alive Dead Aug. 13 19 47

Immediate cause of death	DURATION
Chronic Myocarditis	several years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H.V. Deming M.D. H.V. Deming MD
M. D. or other

Address: Cumberland Md Date signed 8/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

T

VS A15 9-45-15M

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

06628

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: Allegany
County
City or town: R.D. 1, Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: LaVale
R. D. 1. Cumberland, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Near. R. D. 1, Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route #1, LaVale
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MABEL B. GASHAW

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles Gashaw
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): May 20, 1898

8. AGE: Years 49 | Months 3 | Days 5 | If less than one day: hrs. min.

9. Birthplace: Jenners Township, Penna.
(Town, county, and state)

10. Usual occupation: Theotherapist

11. Industry or business

FATHER
12. Name: L. E. Shaulis,
13. Birthplace: P ennsylvania

MOTHER
14. Maiden name: Annie Griffith,
15. Birthplace: Pennsylvania

16. Informant: Charles Gashaw,
Address: R. D. 1, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 28 '47 (month) (day) (year)
Cemetery or crematory: Somerset Memorial Park
Location: Somerset, Penna.

18. Funeral director: J. R. Durst,
Address: Frostburg, Md.

19. Aug. 27 1947 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25 1947, at 2.55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 25 1947 to Aug 25 1947 and that I last saw h[illegible] alive on Aug 25 1947

Immediate cause of death	DURATION
Coronary Thrombosis	2 hrs
Due to: Purpura Hemorrhagica	2 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Allan G. Mumford M.D. or other
Address: Cumberland Md. Date signed: Aug 27 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170c 8

06629

Reg. Dist. No. 4

MV

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 Days

Hospital, Institution, or street address where death occurred:
Allegany Hospital Cumberland Md.

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Pa. County Bedford

City or town (rural) R.F.D. #3 Bedford Valley
(If outside city or town limits, write RURAL and give nearest town)

Street No. Bedford Pa.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Espy W. Growden

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Widowed

6.(b) Name of husband or wife Lillie Growden

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 16- 1877

8. AGE: Years	Months	Days	If less than one day
70	6	15	..... hrs. ..... min.

9. Birthplace Bedford Valley, Bedford Co, Penna
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business "

FATHER
12. Name James Growden
13. Birthplace Bedfrod Valley, Pa.

MOTHER
14. Maiden name Catherine Henderickson
15. Birthplace Flintstone, Md.

16. Informant Mrs. Ralph Oster

Address R.F.D. # 3 Bedford, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/3/47 (month) (day) (year)

Cemetery or crematory Fellowship Cemetery

Location Centerville, Pa.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Sept. 3, 1947 (Date rec'd by registrar) Walter R. Krantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31 19 47 at 3.42 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....

and that I last saw h... im alive Dead Aug. 31 19 47

Immediate cause of death	DURATION
Intracranial hemorrhage	15 days
Due to Fracture of the skull	
Due to Automobile accident	8-16-47
Other conditions fracture of left humerous laceration, right ear contusion right lung	

(Include pregnancy within 3 months of death)

Major findings of operations .....

..... Date of op. .....

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Auto. accident Date of 8-16-47

Where did injury occur? Cumberland (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place, (where?) Bedford St.

Means of injury Growden car ran into another auto during rain storm Injured at work? No

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D. or other

Address Cumberland, Md. Date signed 8/31/47

Deputy Medical Examiner - Allegany Co.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS (A15) 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06639

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 Hrs.

Hospital, Institution, or street address where death occurred:

Miner's Hospital

How long in hospital or institution? 24 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Mt. Crantford Box #2

(If outside city or town limits, write RURAL and give nearest town)

Street No. R. 2, #2 Frostburg, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Edward Darden Sr.

3.(b) Social Security Number 213-03-0342

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Hazel Turnbull

6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Sept. 15th. 1875

8. AGE: Years 71 | Months 10 | Days 28 | If less than one day ... hrs. ... min.

9. Birthplace Eckhart Allegany, Md.

(Town, county, and state)

10. Usual occupation Coal Miner & Retired

11. Industry or business

FATHER 12. Name Samuel Darden

13. Birthplace Eckhart, Md.

MOTHER 14. Maiden name Workman

15. Birthplace Virginia

16. Informant Charles E. Darden

Address Midland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-5-1947 (month) (day) (year)

Cemetery or crematory Forest Cemetery

Location Eckhart, Md.

18. Funeral director Joseph Poole

Address Frostburg, Md.

19. 8-5-47 (Date rec'd by registrar) Mrs. Nancy K. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1947 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 1947 to August 3 1947

and that I last saw him alive on August 3 1947.

Immediate cause of death	DURATION
Carcinoma of stomach	6 mos.
Due to	
Secondary anemia.	
Due to Chronic Syphilitis.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations X Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. Diehl, M.D. M. D. or other

Address Frostburg, Md. Date signed 8/5/47.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

06631

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town ~~453 Bond St.~~ Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about ~~1 year~~ 22 years

Hospital, Institution, or street address where death occurred:
453 Bond St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 453 Bond St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles A. Hess

3.(b) Social Security Number 712-14- 1604

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife Rose L. Wills Hess

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 12-1869

8. AGE: Years	Months	Days	If less than one day
78	6	1	..... hrs. ..... min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation retired Lineman

11. Industry or business C & P T.R.

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name ?

15. Birthplace

16. Informant Powell T. Hess (son)

Address 524 Bedford St. Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 15, 1947 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Aug 15, 1947 (Date rec'd by registrar) W.K. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 13 19 47 at 9 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19 ..... to ..... 19 .....

and that I last saw him alive Dead Aug. 13 19 47

Immediate cause of death Conorary occlusion — DURATION: at once

Due to

Due to

Other conditions Bronchial Asthma

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D. or C.

Address Cumberland, Md Date signed 8-13-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06632

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Gilmore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo. 14

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Gilmore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R. F. D. # 1 Frostburg

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Melvin Leroy House

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	child

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): May 27, 1947

8. AGE: Years: — Months: 2 Days: 14 If less than one day: ... hrs. ... min.

9. Birthplace: Lonaconing, Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business: —

FATHER — 12. Name: Arnold House

FATHER — 13. Birthplace: Lonaconing, Md

MOTHER — 14. Maiden name: Alice Parrish

MOTHER — 15. Birthplace: Keyser, W. Va.

16. Informant: Mrs. Arnold House

Address: Gilmore, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 12 47 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md

16. Funeral director: M. Eichhorn

Address: Lonaconing, Md

19. 8-11 1947 Mrs. Nancy L. Poe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 11 1947 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 8 1947 to Aug 11 1947 and that I last saw h[illegible] alive on Aug 11 1947

Immediate cause of death: Pertussis — DURATION: 3 days

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ...

Means of injury: ... Injured at work?

23. SIGNATURE: W. E. Gatten M.D. M. D. or other

Address: Frostburg, Md Date signed: 8/11/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170d

06633

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A16 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Route 36 near Pekin Md. About 1.1/2 miles west of Lonaconing Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Franklin
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: was in the Navy

3.(a) FULL NAME: James Russell Kenney

3.(b) Social Security Number: 216-22-6209

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 2 1928

8. AGE: Years	Months	Days	If less than one day
19	6	25	hrs. min.

9. Birthplace: Franklin-Allegany-Westernport
(Town, county, and state)

10. Usual occupation: U.S.S.

11. Industry or business: Navy

FATHER
12. Name: Bernard A. Kenny
13. Birthplace: Elk-Garden, W.Va.

MOTHER
14. Maiden name: Marie Hudson
15. Birthplace: Westernport, Md.

16. Informant: Bernard Kenny
Address: Westernport

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 30, 47 (month) (day) (year)
Cemetery or crematory: St. Peters, Cem.
Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal
Address: Westernport, Md.

19. 8-30 1947 (Date rec'd by registrar) Jannette M Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 27 19 47, at 11.55A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on Dead Aug 28 19 47

Immediate cause of death	DURATION
Intracranial hemorrhage	at once
Due to: Depressed fracture of the right frontal bone	
Due to:	
Other conditions: abrasions of both ankles Knees & both forearms	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 8-27-47

Where did injury occur? Route 36 near Pekin, Allegany, Md. about 1.1/2 miles west of Lonaconing Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Motorcycle, skidded Injured at work? no

Deputy Medical Examiner - Allegany Co

23. SIGNATURE: H.V. Deming M.D. H.V. Deming M.D.
M. D. or other

Address: Cumberland Md Date signed: 8/28/47

Within corporate limits

DR. JACOBSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 S

06634

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 7 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County MORGAN
City or town PAW PAW,
(If outside city or town limits, write RURAL and give nearest town)
Street No. /
(If rural, give LOCATION)
2.(a) If veteran, name war Spanish-American

3.(a) FULL NAME MR. CHESTER KIFER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MRS. BESSIE KESLER
6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 5/17/81

8. AGE: Years	Months	Days	If less than one day
66	2	23	....hrs. ....min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation RETIRED Merchant
11. Industry or business Grocer.

FATHER
12. Name DAVID, KIFER
13. Birthplace MARYLAND

MOTHER
14. Maiden name AMANDA ASHKETTLE
15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 13 47 (month) (day) (year)
Cemetery or crematory St Marys Burial Park.
Location RURAL Cumberland Md.
18. Funeral director Lom's Stein Inc
Address Cumberland.

19. Aug. 12, 19 47 (Date rec'd by registrar) Minter R. Fautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 10, 1947, at 5:13 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2 1947, to Aug 10 1947
and that I last saw him alive on Aug 10 1947

Immediate cause of death	DURATION
Myocardial Failure	10 days.
Due to Coronary Artery Sclerosis, Myocardial Hesion, Bundle	?
Due to Cerebral Block (Left)	
Acute Coronin Myocardial Infarction	10 days
Other conditions: Saddle Embolus Common Iliac	1 day.

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Samuel Jacobson M.D.
M. D. or other
Address 50 Pershing St. Date signed 8/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

06635

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

CERTIFICATE OF DEATH

Reg. Dist. No. 4(9)

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Hours

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Penna. County: Bedford

City or town: Rural, Bedford

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harvey Alvin ~~BABY~~ ~~BOY~~ KOONTZ

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1947

8. AGE: Years	Months	Days	If less than one day
			6 hrs. min.

9. Birthplace: Frostburg, Allegany, Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Unknown

13. Birthplace

MOTHER 14. Maiden name: Eleanor Koontz

15. Birthplace: Bedford, Pa.

16. Informant: Mrs. Palmer Pittman

Address: Bedford, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 26, 1947 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Maryland

19. Aug. 25, 1947 (Date rec'd by registrar) Mrs. Nancy K. Rose Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 23, 1947 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 23 1947 to Aug. 23 1947 and that I last saw h alive on Aug. 23 1947

Immediate cause of death	DURATION
Pneumonia, Atelectasis	
Due to	
Due to ?	
Other conditions Mother had mild toxemia.	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W R Hodges, M. D.

Address: Cumberland, Md. M. D. or other

Date signed: 8/25/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

06636

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

638 Dr. J. H. W

CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 61 years

Hospital, institution, or street address where death occurred: 221 Maryland Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 221 Maryland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: DAISY PEARL LANTZ

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John W. Lantz

6.(c) If alive, give age: 71 yrs years

7. Birth date of deceased (mo., day, yr.): August 27, 1886

8. AGE:

Years	Months	Days	If less than one day
61	11	24	..... hrs. ..... min.

9. Birthplace: Westernport, Allegany, Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Own Home

FATHER 12. Name: Charles W. Sultzer

13. Birthplace: Middletown, Maryland

MOTHER 14. Maiden name: Susan Dawson

15. Birthplace: Dawson, Maryland

16. Informant: John W. Lantz

Address: 221 Maryland Ave, Westernport, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 24, 1947 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Maryland

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Maryland

19. Aug 25 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 21 1947 at 6:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1947 to Aug 21 1947 and that I last saw her alive on Aug 21 1947

Immediate cause of death	DURATION
Myocardial Degeneration,	6mo
Due to Endo Carditis,	4yrs
Due to Rheumatic fever.	5yrs
Other conditions Toxic Goiter.	2yrs

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Piedmont W Va Date signed 8-25-47

Within corporate limits 6637

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46b

06637

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, Institution, or street address where death occurred:
502 Warren St.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 502 Warren St.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: Harry Lester Leasure

3.(b) Social Security Number: 214-05-5797

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Agnes Leonard Leasure

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): July 23, 1893

8. AGE: Years: 54 Months: 0 Days: 15 If less than one day: ____ hrs. ____ min.

9. Birthplace: Cheneysville, Pa.
(Town, county and state)

10. Usual occupation: Rural mail carrior

11. Industry or business: U. S. ~~Post~~ P. Office

FATHER
12. Name: Benjamin Leasure
13. Birthplace: Bedford Co., Pa.

MOTHER
14. Maiden name: Malinda Walters
15. Birthplace: Bedford Co. Pa.

16. Informant: Mrs. Agnes Leasure

Address: 502 Warren St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 11, 1947 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Cumberland, Md.

18. Funeral director: John D. Hoffman

Address: Cumberland, Md.

19. Aug 9 1947 (Date rec'd by registrar) Walter R. Lantz, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8 1947, at 4:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1947 to August 8, 1947 and that I last saw him alive on August 8, 1947

Immediate cause of death: Malignant Tumor of abdomen — DURATION: 8 months

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: — Injured at work?

23. SIGNATURE: James J. Johnson M.D. M. D. or coroner

Address: Cumberland, Md. Date signed: 8-9-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

06638

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH:
County: Allegany
City or town: Corriganville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 75 Years
Hospital, institution, or street address where death occurred: Main Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Corriganville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Delrosa Lockard

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Hiram Lockard
6.(c) If alive, give age: yeare

7. Birth date of deceased (mo., day, yr.): May 26 1867

8. AGE: Years	Months	Days	If less than one day
80	2	18	hrs. min.

9. Birthplace: Hastings, Pa. Cambria Co.
(Town, county, and state)
10. Usual occupation: House
11. Industry or business: "

FATHER
12. Name: William McNulty
13. Birthplace: Hollidaysburg, Pa.

MOTHER
14. Maiden name: Margaret Nagle
15. Birthplace: St. Boniface, Pa.

16. Informant: Mrs Jennie Hittie
Address: Carroltown, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/18/47 (month) (day) (year)
Cemetery or crematory: Hill Crest Cemetery
Location: Cumberland, Md.

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. August 18 19 47 J. Lloyd Wolfe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14 19 47 at 9-5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 47 to Aug 14 19 47 and that I last saw h.. alive on Aug 13 19 47

Immediate cause of death: Broncho Pneumonia
Hypostatic Congestion
Due to: Cardiac Insufficiency
Due to:
Other conditions: Fractured Right Leg - 2 yrs.
(Include pregnancy within 3 months of death)

DURATION: Weeks 3 mo.

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert T. Lees M.D.
M. D. or other
Address: 40 4 Decatur Date signed

PLEASE WRITE PLAINLY, WITH INDELIBLE INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06639

160a

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 hrs.

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 10 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Formerly Virginia County: Bedford

City or town: Stephensdale
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Raymond Logsdon

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 7, 1947 @ 9:45 A.M.

8. AGE: Years | Months | Days | If less than one day: 7 hrs. min.

9. Birthplace: Cumberland Alleg. Co. Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Earl Logsdon
13. Birthplace: Pa.

MOTHER
14. Maiden name: Bertha Kirshner
15. Birthplace: Pa.

16. Informant: Earl Logsdon
Address: Hyndman, Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/8/47 (month) (day) (year)

Cemetery or crematory: Hyndman

Location: Hyndman, Pa.

18. Funeral director: H.H. Zeigler

Address: Hyndman, Pa.

19. Aug. 8, 1947 (Date rec'd by registrar) Wilbur L. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 7 1947, at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 7 1947, to Aug 7 1947

and that I last saw him alive on Aug 7 1947

Immediate cause of death	DURATION
(a) Intra Cranial Hemorrhage	7 hrs.
Due to: (b)	
Due to: (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John A Topper M.D.
M. D. or other

Address: Hyndman Pa. Date signed: 8/8/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

C6640

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Cty. Infirmary
How long in hospital or institution? 2 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 26 Lamont St.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Daniel Long

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Cora Gray
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 29, 1880

8. AGE: Years	Months	Days	If less than one day
67	2	9	..... hrs. ..... min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)
10. Usual occupation: Tin Mill Worker
11. Industry or business: N. G. Taylor Co.

FATHER
12. Name: Nelson Long
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Elizabeth McCall
15. Birthplace: W. Va.

16. Informant: Mrs. James L. McDermott
Address: 26 Lamont St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 11, 1947 (month) (day) (year)
Cemetery or crematory: S. S. Peter & Paul
Location: Cumberland, Md.

18. Funeral director: H. Wayne George
Address: Cumberland, Md.

19. Aug. 9, 1947 (Date rec'd by registrar) Wesley R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 8, 1947, at 8:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1906 to Aug 8 1947
and that I last saw him alive on Aug 5 1947

Immediate cause of death	DURATION
Cent. supraventricular failure	10 min
Due to Generalized Arteriosclerosis	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Arthur F. Jones M.D. M. D. or other
Address: 110 S. Centre St Date signed: 8-9-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06641

92d

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Goodfellowship Club 214.1/2 Va.Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 100 W. Second St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Arthur LeRoy Mc Cormick

3.(b) Social Security Number

217-10-6258

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Hazel Willison McCormick

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): March 4 1912

8. AGE: Years	Months	Days	If less than one day
35	5	3	hrs. min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Celanese Corp. of Am.

11. Industry or business

FATHER — 12. Name: Joseph A. McCormick

13. Birthplace: Cumberland, Md.

MOTHER — 14. Maiden name: Anna Miller

15. Birthplace: Cumberland, Md.

16. Informant: Mrs. Hazel McCormick

Address: 100 W. Second St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/10/47 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Aug. 9 (Date rec'd by registrar) 19 47 Clinton L. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 7 19 47 at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...

and that I last saw him alive Dead Aug. 7 19 47

Immediate cause of death: Acute Dilatation of the heart — DURATION: at once

Due to: a chronic valvular heart disease — several years

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V.Deming M.D. H.V.Deming M.D.
M. D. or other

Address Cumberland, Md Date signed 8-7-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

DR. W. F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

06642

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Days
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town FLINTSTONE
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MRS. CLARA S. McFARLAND

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

8.(b) Name of husband or wife WILLIAM McFARLAND
8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 22, 1875

8. AGE: Years	Months	Days	If less than one day
72	1	12	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name SABRIAL THORTON McKENZIE
13. Birthplace MD.

MOTHER
14. Maiden name MARY M. GREENWADE
15. Birthplace MD.

16. Informant Memorial Hospital
Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/6/47 (month) (day) (year)
Cemetery or crematory Bier Cemetery
Location Rawlings, Md.

18. Funeral director William H. Kight
Address Cumberland, Md.

19. Aug 6 1947 (Date rec'd by registrar) Walter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 4, 1947 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-31- 19 47 to 8-4- 19 47
and that I last saw h e alive on 8-3- 19 47

Immediate cause of death	DURATION
Acute Myocardial	
Due to Degeneration	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other
Address Cumberland Date signed 8-4-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reno

94a

06643

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 years

Hospital, institution, or street address where death occurred: 166 Bines Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Westernport, Md (If outside city or town limits, write RURAL and give nearest town)

Street No.: 166 River road (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Mary B. McGuigan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 21st 1873.

8. AGE:

Years	Months	Days	If less than one day
74	6	26	hrs. min.

9. Birthplace: Westernport Allegany Co. Md. (Town, county, and state)

10. Usual occupation: Registered Nurse

11. Industry or business

FATHER

12. Name: John McGuigan

13. Birthplace: Orleans Allegany Co. Md

MOTHER

14. Maiden name: Ellen Naughton

15. Birthplace: Eckhart Allegany Co. Md.

16. Informant: Catherine McGuigan Laughlin

Address: Westernport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 19 1947 (month) (day) (year)

Cemetery or crematory: St Peters Cem

Location: Westernport, Md

16. Funeral director: Ellsworth & Beal

Address: Westernport, Md

19. Aug 18 1947 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 16, 1947, at P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 14, 1947, to Aug 16, 1947 and that I last saw her alive on Aug 16, 1947

Immediate cause of death	DURATION
Acute Coronary Occlusion	2 days
Due to: Coronary Arteriosclerosis	
Due to:	
Due to:	
Other conditions: Broncho-pneumonia (terminal)	1 day

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Thomas Reese M.D. M. D. or other

Address: Westernport, Md. Date signed: 8-18-47

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15 9-45-15M

Within corporate limits — Dr. Durrett

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06644

74a

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 53 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Little Orleans
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: World Wars I and II

3.(a) FULL NAME
John Merica

3.(b) Social Security Number
722-12-0029

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Gladys Snyder

6.(c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): April 22, 1898

8. AGE: Years	Months	Days	If less than one day
50	3	25	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Carpenter Helper

11. Industry or business: Western Maryland Railroad

FATHER — 12. Name: George Merica

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Annie Baker

MOTHER — 15. Birthplace: Virginia

16. Informant: Memorial Hospital

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 20, 1947 (month) (day) (year)

Cemetery or crematory: Rubys Cemetery

Location: Green Ridge Station, Md.

18. Funeral director: H. Wayne George

Address: Cumberland, Md.

19. Aug 19 1947 (Date rec'd by registrar) Hunter R Rody M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17, 1947, at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5, 1947, to Aug. 17, 1947 and that I last saw him alive on Aug. 17, 1947

Immediate cause of death	DURATION
Anoxic encephalogenous Leukemia	4 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Geo. R. Jones M. D. or other

Address: Cumberland Date signed: Aug. 18, 1947.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

Fair Rec'd

06645

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

117 L

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Allegany Inn
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: David Gregory Murray

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	~~Married~~ Divorced

6.(b) Name of husband or wife: Georgiana Wilson

6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): March 31, 1896

8. AGE:

Years	Months	Days	If less than one day
51	5	0	..... hrs. ..... min.

9. Birthplace: Vale Summit, Md
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: U. S. Post Office

FATHER
12. Name: David G. Murray
13. Birthplace: Scotland

MOTHER
14. Maiden name: Catherine Larin
15. Birthplace: Unknown

16. Informant: Mary C. Schaaf

Address: 192 N. Center St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof September 3, 1947 (month) (day) (year)

Cemetery or crematory: Sts. Peter & Paul's Cemetery

Location: Cumberland, Md

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Sept. 2 1947 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 31, 1947, at 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 30 1947 to Aug 31 1947 and that I last saw him alive on Aug 31, 1947

	DURATION
Immediate cause of death: Hypertension	30 hrs
Due to: Perforated duodenal ulcer	3 hrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Hypertension perforated duodenal ulcer Date of op. 8/31/47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. Wells M. D. or Coroner

Address: 404 Leader Date signed: 9/8/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

164c

06646

Reg. Diat. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all his life

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8 Washington St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

John Wallace Price Nichols

3.(b) Social Security Number 217-05-9873

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Pricella Jones Nichols

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): Oct. 30- 1898

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
48	9	19		

9. Birthplace: Lonaconing Md.
(Town, county, and state)

10. Usual occupation: miner

11. Industry or business: coal

FATHER — 12. Name: James N.Nichols

FATHER — 13. Birthplace: Pa.

MOTHER — 14. Maiden name: Gertrude Thrasher

MOTHER — 15. Birthplace: Mich.

16. Informant: Mrs Pricella Nichols

Address: Lonaconing, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 22, 1947 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md

18. Funeral director: M Eichhorn

Address: Lonaconing, Md

19. 8/22 (Date rec'd by registrar) 1947 Jannette M Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 19 19 47 at 5.45P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw him alive Dead Aug. 19 19 47

Immediate cause of death: Pulmonary hemorrhage — DURATION: at once

Due to: 12 guage shot gun wound in apex left chest.

Due to: Worry & bad health.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: 8-19-47

Where did injury occur? Lonaconing (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?): home

Means of injury: as above Injured at work? no

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H.V.Deming M.D. H.V.Deming M.D.
M. D. or other

Address: Cumberland, Md Date signed: 8/19/47

PLEASE WRITE PLAINLY, WITH (illegible) INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06647

61

CERTIFICATE OF DEATH

Reg. Dist. No. 4

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Allegheny

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 Days

Hospital, Institution, or street address where death occurred:
Allegheny Hospital

How long in hospital or institution? 21 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 435 Goethe St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: John William Noonan

3.(b) Social Security Number: 214-05-4598

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Parrish Noonan

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): September 28, 1879

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
67	10	7		

9. Birthplace: Keyser, Mineral Co, West Virginia
(Town, county, and state)

10. Usual occupation: Labor

11. Industry or business: Pen-Mar Brick & Tile Co

FATHER
12. Name: Patrick Noonam
13. Birthplace: Ireland

MOTHER
14. Maiden name: Ellen Yost
15. Birthplace: Westernport, Md.

16. Informant: Mrs. J. W. Noonan
Address: 435 Goethe St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/8/47 (month) (day) (year)

Cemetery or crematory: St Peter & Paul Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Aug 7 1947 (Date rec'd by registrar) Walter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5 1947 at 10-15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15, 1947 to Aug. 5, 1947 and that I last saw him alive on 8-5- 1947

Immediate cause of death	DURATION
Diabetes Mellitus --Several years	
Due to:	
Due to:	
Other conditions: Prostatic hypertrophy -several months	

(Include pregnancy within 3 months of death)

Major findings of operation: Cystocretes Right Inguinal Hernia Date of op. 7-25-47

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: [illegible] Date signed 8-6-47

Outside of City Limits

06648

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170C

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Route 40 - West Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Died enroute to Memorial Hosp.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Little Orleans
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME William Marvin Norris

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 7 - 1938

8. AGE: Years 9 | Months 0 | Days 19 | If less than one day ..... hrs. ..... min.

9. Birthplace Piney Plains, Allegany Co, Md
(Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER 12. Name Donald Norris

13. Birthplace Little Orleans Md

MOTHER 14. Maiden name Sarah Beatrice Bowman

15. Birthplace Artemus Pa

16. Informant Father.

Address Little Orleans Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 30 1947 (month) (day) (year)

Cemetery or crematory Piney Plains Cem

Location Piney Plains, Md

18. Funeral director Charles R. East

Address Hancock, Md.

19. Aug. 29, 1947 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1947 at 6 35 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him ALIVE 19 47 DEAD

Immediate cause of death Broken neck — DURATION

Fracture of 6th cervical vertebra — about 5 min.

Due to

Due to

Other conditions Laceration of carotid artery

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 8/26/47

Where did injury occur? Belle Grove (City or town) Allegany (County) Md (State)

Injured at home, farm, industry, public place (where?) Route 40 27 miles East of Cumberland Md

Means of injury Automobile door flew open + boy fell out, Head struck ground. Injured at work? No.

23. SIGNATURE C. V. Deming M.D. M. D. or other

Address Cumberland Md Date signed 8/26/47

Deputy Medical Examiner - Allegany Co.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 175c

06649

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs.
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 505 Maryland Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Benjamin Riley North

3.(b) Social Security Number 714-10-5316

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Ester Wilson North
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Sept. 29- 1877

8. AGE: Years	Months	Days	If less than one day
69	10	22	... hrs. ... min.

9. Birthplace Murleys Branch, Allegany, Md. (Town, county, and state)
10. Usual occupation retired -
11. Industry or business Potomac Edison Co.

FATHER
12. Name Henry North
13. Birthplace Murley Branch Md.

MOTHER
14. Maiden name Elizabeth Athey
15. Birthplace Md.

16. Informant Mrs. Benjamin R. North
Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 23 47 (month) (day) (year)
Cemetery or crematory Rolleces Gm.
Location Cumberland Md.

18. Funeral director Louis Stein Inc
Address Cumberland

19. Aug. 23 1947 (Date rec'd by registrar) Winters R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 19 47 at 11.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...
and that I last saw him alive Dead Aug. 21 19 47

Immediate cause of death Pulmonary Embolism — DURATION: at once

Due to (Accident) 8-7-47 Fracture (compressed) 12 dorsal

Due to 2nd & 4th. lumber vertebrae also anterior displacement of

Other conditions the 5th. lumber.

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 8-7-47
Where did injury occur? Murley Branch (City or town) Allegany (County) Md. (State)
Injured at home, farm, industry, public place (where?) farm
Means of injury Up on ladder picking pears, 15 ft. limb broke & he fell to ground..

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V. Deming M.D. H. V. Deming M.D.
M. D. or other
Address Cumberland, Md. Date signed 8-22-47

Wilson 06650

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH
County Allegany
City or town Barton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Barton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Carson Allen Perkins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 20 1909

8. AGE: Years 38 Months 6 Days 16 If less than one day ... hrs. ... min.

9. Birthplace Jennings-Tucker W. Va (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Mason S. Perkins
13. Birthplace Staunton, Va

MOTHER 14. Maiden name Elizabeth Hunsinger
15. Birthplace Calliz, Penna.

16. Informant Mrs. M. G. Perkins
Address Barton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 21 1947 (month) (day) (year)
Cemetery or crematory Laurel Hill
Location Morgan, Md.

18. Funeral director E. Ellsworth Borden
Address Westernport Md.

19. Aug 18 1947 (Date rec'd by registrar) [signature] M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1947 at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 10, 1946, to Aug 18 1947 and that I last saw him alive on Aug 18 1947

	DURATION
Immediate cause of death Lobar Pneumonia	2 Days
Due to	
Due to	
Other conditions Pulmonary Tuberculosis	1 Year

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Paul R. Wilson M.D. M. D. or other
Address Piedmont, W. Va Date signed Aug 18, 1947

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

06651

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
B.& O.Y.M.C.A - Virginia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: First World War

3.(a) FULL NAME: Theodore Lynn Pickrell

3.(b) Social Security Number: 494-09-8402

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Effie Stevens Pickrell

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Dec. 7.1887

8. AGE: Years	Months	Days	If less than one day
59	8	17	hrs. min.

9. Birthplace: St. Louis Mo.
(Town, county, and state)

10. Usual occupation: Night clerk

11. Industry or business: B.& O. Y.M.C.A.

FATHER
12. Name: Frank Pickrell
13. Birthplace: Mo.

MOTHER
14. Maiden name: Dora Dildine
15. Birthplace: Mo.

16. Informant: wife

Address: Mt. Savage Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 29 '47 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: J. R. Durst,

Address: Frostburg, Md.

19. Aug 28 1947 (Date rec'd by registrar) Hunter R Dent M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 26 19 47 at 9.35P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive Dead Aug. 26 19 47

Immediate cause of death	DURATION
Coronary occlusion	at once
Due to: myocarditis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE: H.V.Deming M.D. H.V.Deming M.D. (M. D. or other)

Address: Cumberland, Md. Date signed: 8.27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

DR COOPER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06652

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? MEMORIAL

Hospital, institution, or street address where death occurred:
MEMORIAL HODSPITAL

How long in hospital or institution? 30 MINUTES

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 432 CENTRE ST
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

RINGER ~~BABY BOY~~ Wayne Allen

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 14, 1947 @ 12:50 A.M.

8. AGE: Years	Months	Days	If less than one day
			hrs. 30 min.

9. Birthplace CUMBERLAND, Alleg. Co., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name ALVA RINGER
13. Birthplace W.VA

MOTHER
14. Maiden name THELMA GARLITZ
15. Birthplace W.VA

16. Informant Memorial Hospital
Address Cumberland, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof AUG. 14, 1947 (month) (day) (year)

~~Cemetery~~ crematory MEMORIAL
Location CUMBERLABND MD.

18. Funeral director Same as above
Address

19. Aug. 14, 1947 (Date rec'd by registrar) Walter L. Fauth, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 14, 1947 19 ..... at 1:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 Aug 19 47 to 14 Aug 19 47 and that I last saw him alive on 14 Aug 19 47

Immediate cause of death	DURATION
Congenital Atelectasis multiple Congenital Anomalys	
Due to Congenital Malformation	
Due to	
Other conditions Poly dactylism — Hemangiocardiac.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dallas B Wentworth M. D. or other

Address 112 Bedford St. Date signed 14 Aug 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. W. C. Lane

83a

06653

CERTIFICATE OF DEATH

Reg. Dist. No. 9

M

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all her life

Hospital, Institution, or street address where death occurred: 9 Ormand St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give neareat town)

Street No.: 9 Ormand St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ANNIE SMITH

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 1, 1871

8. AGE:

Years	Months	Days	If less than one day
76	7	15	..... hrs. ..... min.

9. Birthplace: Frostburg, Allegany, Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business: home

FATHER — 12. Name: John Smith

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Anna Farrady

MOTHER — 15. Birthplace: Wellersburg, Pa.

16. Informant: Miss Effie Smith,

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 18 '47 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: J. R. Durst,

Address: Frostburg, Md.

19. 8-18 (Date rec'd by registrar) 1947 Mrs. Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 16 1947, at 12:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 12 1947 to Aug 16 1947 and that I last saw her alive on Aug 13 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	8 Days
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Wm C Lane M. D. or other

Address: Frostburg Md. Date signed 8-18-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr Paul R. Wilson

932

06654

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred: Hill Top Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. Hill Top Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: JOHN HOWARD SMOUSE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Henrietta Smouse

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): September 9, 1867

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
79	11	17		

9. Birthplace: Grantsvill, Garrett, Maryland (Town, county, and state)

10. Usual occupation: Blacksmith

11. Industry or business: Paper Mill

FATHER — 12. Name: Daniel Smouse

FATHER — 13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Priscilla Livengood

MOTHER — 15. Birthplace: Pennsylvania

16. Interment: Fay E. Plaugher

Address: Westernport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 30, 1947 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Maryland

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Maryland

19. Aug. 30 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26 1947 at 8:20a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1947 to Aug. 26 1947 and that I last saw h... alive on Aug 26 1947

Immediate cause of death	DURATION
Chronic Myocarditis and Myocardial Degeneration Not Specified As Rheumatic	2 Years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul R Wilson MD M. D. or other

Address: Piedmont W.Va Date signed Aug 29, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06655

Reg. Dist. No. 4

M

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 Years
Hospital, institution, or street address where death occurred: 427 Independence St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 427 Independence St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Geneva Sowers

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Hiram Sowers
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 9 1860

8. AGE: Years	Months	Days	If less than one day
87	7	5	..... hrs. ..... min.

9. Birthplace: Chaneysville, Bedford Co, Pa
(Town, county, and state)
10. Usual occupation: House
11. Industry or business: "

FATHER
12. Name: Jesse Howser
13. Birthplace: Chaneysville, Pa.

MOTHER
14. Maiden name: Clara Rolland
15. Birthplace: Chaneysville, Pa.

16. Informant: Marshall Sowers
Address: 316 Columbia St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/16/47 (month) (day) (year)
Cemetery or crematory: Mt. Zion Cemetery
Location: Chaneysville, Pa.

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. Aug. 15 1947 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14 1947, at 4-20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June-19-- 1944 to Aug-14 1947 and that I last saw h-- alive on Aug 14 1947

Immediate cause of death	DURATION
Chronic Hypocondria	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: T. D. Weakley M.D. M. D. or other
Address: 49 Green St Date signed 8/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

06656

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Midland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Midland
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: John Ernst Steiding

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Elizabeth J. Steiding
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 24, 1859.

8. AGE: Years 88 | Months 2 | Days 17 | If less than one day ____ hrs. ____ min.

9. Birthplace: Barton Allegany Co. Md.
(Town, county, and state)

10. Usual occupation: Contractor

11. Industry or business: Carpenter

FATHER
12. Name: Barnhardt Steiding
13. Birthplace: Germany

MOTHER
14. Maiden name: Batrie
15. Birthplace: Germany

16. Informant: John B. Steiding
Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 13, 1947 (month) (day) (year)
Cemetery or crematory: K. of P. Memorial Cemetery
Location: Elk Garden, W. Va.

18. Funeral director: W. D. Eichhorn
Address: Lonaconing, Md.

19. Aug 12 1947 (Date rec'd by registrar) Jannetton Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/11/1947 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/9/1947 to 8/11/1947 and that I last saw h.i.m. alive on 8/9/1947

Immediate cause of death	DURATION (?)
Coronary Thrombosis	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

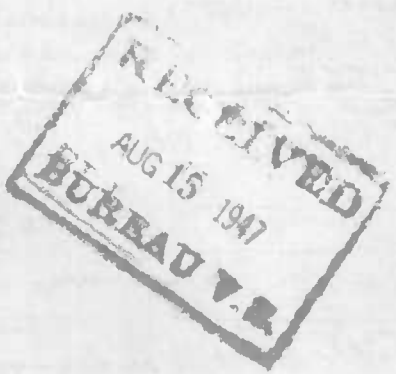
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: Paul Eugene Frye M.D.
(M. D. or other)
Address: Lonaconing, Md. Date signed: 8/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06657

174

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Miner's Hospital Frostburg Md.

How long in hospital or institution? 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Robert L. Sturtz

3.(b) Social Security Number: 220-26-9224

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 21, 1930

8. AGE: Years: 17 Months: 4 Days: 28 If less than one day: ..... hrs. ..... min.

9. Birthplace: Wellersburg, Somerset, Penna. (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: coal mines

FATHER

12. Name: Walter Sturtz

13. Birthplace: Pennsylvania

MOTHER

14. Maiden name: Edith Porter

15. Birthplace: Maryland

16. Informant: Walter Sturtz,

Address: Slabtown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 22'47 (month) (day) (year)

Cemetery or crematory: Cook Cemetery,

Location: Wellersburg, Pa.

18. Funeral director: J. R. Durst,

Address: Frostburg, Md.

19. 8-21 1947 Mrs. Nancy N. Roe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 20 19 47, at 1.55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive Dead Aug 20 19 47

Immediate cause of death	DURATION
Intracranial hemorrhage	12 hrs.
Due to basial fracture of the skull	
fractures of right malar, nasal	
Due to & superior maxillary bones	
a stone in roof of mine falling	
Other conditions & hitting him on right side of face.	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 8-19-47

Where did injury occur? near Eckhart (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) Micheals Mine

Means of injury as above Injured at work? yes

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.

M. D. or other

Address Cumberland, Md. Date signed 8-20-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06658

Reg. Dist. No. 4

DR. GRACIE

46g

1. PLACE OF DEATH

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town LONACONING

(If outside city or town limits, write RURAL and give nearest town)

Street No. 58 JACKSON

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME MR. ELLIOTT TERNENT

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) SEPTEMBER 23, 1886

8. AGE: Years	Months	Days	If less than one day
60	10	25	... hrs. ... min.

9. Birthplace MARYLAND (town, county, and state)

10. Usual occupation BLACKSMITH

11. Industry or business Own shop

FATHER 12. Name JAMES TERNENT

13. Birthplace MARYLAND

MOTHER 14. Maiden name EMMA HUTSON

15. Birthplace ENGLAND

16. Informant Mrs. Emma Ternent Mead

Address Westport, New York

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 20 1947 (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Lonaconing, Md.

18. Funeral director M. Eichelberger

Address Lonaconing, Md.

19. Aug. 20, 19 47 (Date rec'd by registrar) Winter L. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 18, 1947 2:50 A.M. 19 ... at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26 1947 to Aug 18 1947 and that I last saw him alive on Aug 17 1947

Immediate cause of death	DURATION
Carcinomatosis	
Due to Carcinoma? pancreas	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Fluid + masses through at down Date of op. Aug 4-47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. Gracie M. D. or other

Address Cumberland Md Date signed Aug 18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06659

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rawlings

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Delphia Pearl Thrasher

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Nelson D Thrasher

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 27 1901

8. AGE: Years	Months	Days	If less than one day
45	7	29	..... hrs. ..... min.

9. Birthplace Red Creek W. Va. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

12. FATHER Name Wm H Flanagan

13. FATHER Birthplace W. Va.

14. MOTHER Maiden name Rebecca Simmons

15. MOTHER Birthplace W. Va

16. Informant Nelson D Thrasher

Address Rawlings Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 24 '47 (month) (day) (year)

Cemetery or crematory Burton Cem

Location Bier Md.

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Aug 24 1947 (Date rec'd by registrar) Winter R Trautwein Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1947, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 17 1947, to Aug 21 1947

and that I last saw h.. alive on Aug 21 1947

Immediate cause of death	Uremia	DURATION
Due to	Glomerulonephritis	
Due to	Hypocardial degeneration	
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE E Kesler M. D. or other

Address 112 Bedford St Date signed 8/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06660

83a

CERTIFICATE OF DEATH

Reg. Diat. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs
Hospital, institution, or street address where death occurred: Detmold
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No. Detmold
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME Florence Thursby Turnbull

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~ Robert Turnbull
6.(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.): Feb. 29 1876

8. AGE: Years 71 Months 6 Days 2 If less than one day ..... hrs. ..... min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

MOTHER FATHER
12. Name: John Murphy
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Phoebe O'Haver
15. Birthplace: Unknown

16. Informant: Mrs. Florence Liller
Address: Easton, Md.

17. Burial (If burial, cremation, or removal. Which?) Date thereof: Sept 3, 1947 (month) (day) (year)
Cemetery or crematory: Laurel Hill Cemetery
Location: Mt. Savage, Md.

18. Funeral director: Mr. Dickhom
Address: Lonaconing, Md.

19. 9/3 19 47 Jeanette M Beal Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 31 19 47 at 12:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 19 47 to Aug 31 19 47 and that I last saw her alive on Aug 30 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 Days
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Paul B Wilson MD M. D. or other
Address: Piedmont, W. Va. Date signed: Sept 2, '47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

572

06661

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 418 Grand Ave.,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 418 Grand Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Margaret Ann Twigg

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Randolph Twigg
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 24, 1879

8. AGE: Years	Months	Days	If less than one day
68	5	12	..... hrs. ..... min.

9. Birthplace: Little Orleans, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Michael Keefer
13. Birthplace: Penna.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Irene Galliher
Address: 418 Grand Ave., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 9, 1947 (month) (day) (year)
Cemetery or crematory: Methodist Cem.
Location: Little Orleans, Md.

18. Funeral director: H. Wayne George
Address: Cumberland, Md.

19. Aug. 7, 1947 (Date rec'd by registrar) Wm. L. Trautman M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 6, 1947 at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 1947 to Aug 6 1947 and that I last saw h-e alive on Aug 1 1947

Immediate cause of death	DURATION
Pneumonia	
R. Kiernan	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: /
Date of op.
Autopsy results: not
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: C. Kiernan M. D. or other
Address ..... Date signed .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

06662

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 61 yrs

Hospital, Institution, or street address where death occurred:

1504 Bedford St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1504 Bedford St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Rudolph Frank Valentine

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of ~~husband~~ or wife: Lena Elder

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 17, 1886

8. AGE: Years 61 | Months 3 | Days 29 | If less than one day ..... hrs. ..... min.

9. Birthplace: Cumberland Md (Town, county, and state)

10. Usual occupation: Truck Gardner

11. Industry or business: Self

FATHER

12. Name: Lloyd R. Valentine

13. Birthplace: Md.

MOTHER

14. Maiden name: Annie Lutzman

15. Birthplace: Md.

16. Informant: Mrs R F Valentine

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 18 47 (month) (day) (year)

Cemetery or crematory: Green Memorial Cem

Location: Near Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland.

19. Aug 18, 1947 (Date rec'd by registrar) White L. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 16 1947 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/11/42 to 8/14/47 and that I last saw ~~deceased~~ alive on Aug 16 1947

Immediate cause of death	DURATION
Coronary Sclerosis	5 yrs
Arterial Hypertension	10 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: B. M. Stein M.D.

Address Cumberland Md ..... M. D. or other

Date signed 8/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06663

Reg. Diat. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Insure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Ecklehart

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Ecklehart

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth Jane Watson

3.(b) Social Security Number: 212-24-1986

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): May 25th, 1928

8. AGE:

Years	Months	Days	If less than one day
19	4	26	... hrs. ... min.

9. Birthplace: Mine's Run, Frostburg, Md. (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Maryola's Fox & Tea

FATHER 12. Name: John P. Watson

13. Birthplace: Ecklehart, Md.

MOTHER 14. Maiden name: Nellie Bannatyne

15. Birthplace: Ecklehart, Md.

16. Informant: John P. Watson

Address: Ecklehart, Md.

17. Burial, cremation, or removal. Which? Burial Date thereof 8-24-1947 (month) (day) (year)

Cemetery or crematory: Ecklehart Cem.

Location: Ecklehart, Md.

18. Funeral director: Jacob Kaler

Address: Frostburg, Md.

19. 8-22 1947 (Date rec'd by registrar) Mrs Nancy V. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 21 1947 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19 1947 to August 21 1947 and that I last saw her alive on August 21 1947.

Immediate cause of death	DURATION
Acute Cardiac dilitation.	15 min.
Due to Chronic rheumatic heart disease.	
Due to	
Other conditions X	

(Include pregnancy within 3 months of death)

Major findings of operations: X Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: X Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. C. Diehl, M.D. M. D. or other

Address: Frostburg, Md. Date signed 8-23-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06664

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: W. Va. County: Mineral
City or town: Ridgeley
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 47 Knobley St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: VIRGINIA LEE WEAVER

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: None
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 9, 1947

8. AGE: Years	Months	Days	If less than one day
0	0	4	hrs. min.

9. Birthplace: Cumberland, Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business: None

FATHER
12. Name: John R. Weaver
13. Birthplace: Cumberland, Md.

MOTHER
14. Maiden name: Virginia Grimes
15. Birthplace: Ridgeley, W. Va.

16. Informant: Mr. John R. Weaver
Address: 47 Knobley St., Ridgeley, W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 15, 1947 (month) (day) (year)
Cemetery or crematory: Zion Memorial Cem.
Location: Cumberland, Md.
18. Funeral director: H. Wayne George
Address: Cumberland, Md.

19. Aug. 14, 1947 (Date rec'd by registrar) Walter L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 13, 1947, at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Aug. 1947 to 13 Aug. 1947
and that I last saw h. alive on 13 Aug. 1947

Immediate cause of death	DURATION
Congenital Athelectasis	
Due to: Congenital Heart Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Fuller B. Whitworth M. D. or other
Address: Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

7507

184

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Mc.Coole Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Hospital On McCoole bridge going to Keyser

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)

Street No. 463 Spruce St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Pearson Charles Welsh

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 15 1930

8. AGE: Years	Months	Days	If less than one day
16	7	18	..... hrs. ..... min.

9. Birthplace: Thomas W.Va. (Town, county, and state)

10. Usual occupation: Student

11. Industry or business

FATHER — 12. Name: Oran Welsh

13. Birthplace: Westernport Md.

MOTHER — 14. Maiden name: Marguerite White Welsh

15. Birthplace: Cleveland Ohio.

16. Informant: Oran Welsh

Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 6 47 (month) (day) (year)

Cemetery or crematory: Pulaski Cem.

Location: Westernport, Md.

18. Funeral director: Ellsworth S. Bosh

Address: Westernport, Md.

19. Aug 6 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 3 1947, at 2.40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.... to ..... 19.....

and that I last saw him alive Dead Aug. 3 1947

Immediate cause of death: Intraabdominal hemorrhage & Shattered lumber spine — DURATION: about 40 minutes

Due to: 12 guage shot gun wound

Due to: Companion with gun stumbled over R.Ry tie & gun went off accidently, while hunting.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 8-3-47

Where did injury occur? About 2.1/2 mi. west of Rawlings on W.Md.R.Ry. (Town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) as above

Means of injury as above Injured at work? no

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H.V.Deming M.D. H V Deming MD M. D. or other

Address: Cumberland Md. Date signed: 8/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

DR. HAWKINS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06665

CERTIFICATE OF DEATH

46 b

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 DAYS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 10 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: West Virginia County: Mineral
City or town: Rural Near Keyser
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R. F. D. #1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MRS. PHEBE WESTFALL

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: CKARENCE O. WESTFALL
6.(c) If alive, give age: 65 years
7. Birth date of deceased (mo., day, yr.): APRIL 4, 1885

8. AGE: Years	Months	Days	If less than one day
62	4	12	..... hrs. ..... min.

9. Birthplace: PENNSYLVANIA (Town, county, and state)
10. Usual occupation: HOUSEWIFE
11. Industry or business

FATHER
12. Name: GEORGE BROWN
13. Birthplace: PENNSYLVANIA

MOTHER
14. Maiden name: ANNIE SMITH
15. Birthplace: PENNSYLVANIA

16. Informant: Clarence O. Westfall
Address: Rt. #1, Keyser, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 19, 1947 (month) (day) (year)
Cemetery or crematory: Queenspoint Cem.
Location: Keyser, W. Va.

18. Funeral director: N. H. Rogers
Address: Keyser, W. Va.

19. Aug. 19 1947 (Date rec'd by registrar) Winter R. Fantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUGUST 16, 1947 at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 6, 1947 to August 16 1947 and that I last saw her alive on August 16, 1947

Immediate cause of death: Diff. Supp. Peritonitis DURATION
Leak stitch line - Esophagus
Jejunotomy —
Due to: Total Gastrectomy for
Carcinoma Stomach
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: Autopsy Dissolvation stitch line - Diff. Peritonitis
Autopsy (Yes or No) Results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. H. Hawkins M. D. or other
Address: Date signed 8-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

36

06666

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 300 N. Center St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bernard Joseph Ronald Wickard

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 15, 1942

8. AGE: Years	Months	Days	If less than one day
5	2	10	____ hrs. ____ min.

9. Birthplace Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation child

11. Industry or business

FATHER 12. Name Arthur C.V.A. Wickard

FATHER 13. Birthplace Cumberland, Md.

MOTHER 14. Maiden name Helen W. Deter

MOTHER 15. Birthplace Cumberland, Md.

16. Informant Arthur C.V.A. Wickard

Address 300 N. Center St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 29 1947 (month) (day) (year)

Cemetery or crematory St. Patricks Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. Aug. 29, 1947 (Date rec'd by registrar) Walter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1947, at 10:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 23 1947 to August 25 1947 and that I last saw him alive on August 25 1947

Immediate cause of death	DURATION
Enterocolitis	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE B. M. Schneider M.D.
M. D. or other

Address 41 Bennett Date signed August 28/1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

930

06667

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 12 Uhl St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 12 Uhl

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Susan M. Wiebrecht

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Henry Wiebrecht

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): June 12 - 1876

8. AGE: Years: 71 Months: 2 Days: 3 If less than one day: hrs. min.

9. Birthplace: Lonaconing - Alleg - Md. (town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER — 12. Name: David McIntyre

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Elizabeth Hartley

MOTHER — 15. Birthplace: Scotland

16. Informant: Mrs Mary Nickel

Address: Frostburg, md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 17-1947 (month) (day) (year)

Cemetery or crematory: Zion Evangelical

Location: Frostburg md.

18. Funeral director: J. J. Durst

Address: Frostburg, Md.

19. 8-15-1947 (Date rec'd by registrar) Mrs Nancy K Rice Registrar

MEDICAL CERTIFICATION

E.D.S.T.

20. DATE OF DEATH: August 15 1947 at 17 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 9 1944 to August 15 1947, and that I last saw h.e.r alive on August 15 1947.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	18 hrs.
Due to: Hypertension	
Due to: Pernicious anemia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl M.D. M. D. or other

Address: Frostburg, Md. Date signed: 8/15/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06668

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 323 Cumberland St.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Charles W. Willison

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Amanda Bennett

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Dec 16 1869

8. AGE:

Years	Months	Days	If less than one day
77	7	22	____ hrs. ____ min.

9. Birthplace: Filmstone Ind.
(Town, county, and state)

10. Usual occupation: Merchant (Retired)

11. Industry or business: Hardware

FATHER
12. Name: Hilary F. Willison
13. Birthplace: Ind.

MOTHER
14. Maiden name: Elmira Hendrickson
15. Birthplace: Ind.

16. Informant: Clifford W. Willison
Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 11 47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland.

18. Funeral director: Louis Stein Inc

Address: Cumberland.

19. Aug. 11, 1947 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 8 1947 at 6:15 A

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 23 1947, to 8-8-1947 and that I last saw him alive on 8-8-1947

Immediate cause of death	DURATION
Cerebral Thrombosis	Since 7-22-47
Due to: Generalized Arteriosclerosis	
Due to: Coronary Sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None

Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Wm. J. Williams M. D. or other

Address: Cumberland Date signed 8-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. McLane 16669

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: W. Main Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: W. Main
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Anna May Wilson

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Calvin Wilson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 20, 1877

8. AGE: Years 70 | Months 1 | Days 11 | If less than one day ..... hrs. ..... min.

9. Birthplace: Garrett City, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: George Crowe
13. Birthplace: Maryland

MOTHER
14. Maiden name: Louise Carney
15. Birthplace: Maryland

16. Informant: Jerome Wilson
Address: Frostburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 3 1947 (month) (day) (year)
Cemetery or crematory: Johnson Cemetery
Location: Garrett Co. Md.
18. Funeral director: J. R. Durst
Address: Frostburg Md.

19. 9-2 (Date rec'd by registrar) 1947 Mrs Hadley N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 31 1947, at 10:00 P.M. Sun

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to Aug 31 1947 and that I last saw h.er alive on Aug 31 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 Day
R.T. Hemiplegia	
Due to	
Due to	
Other conditions Carcinoma - Cause not determined, patient died as result of cerebral hemorrhage (Include pregnancy within 3 months of death)	2 wks

Major findings of operations: Exploratory laparotomy - final diagnosis could be made. Was suspicious of pancreatic malignancy in region of common duct or pancreas. Date of op. (9/24/47 as)

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: W. O. McLane M.D. M. D. or other
Address: Frostburg Md Date signed Sept 2 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

DR. W. F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1176

06670

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or Institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town Nat'l CUMBERLAND, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. ROUTE # 4
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MR. CHARLES W. WOLFORD

3.(b) Social Security Number 213-12-9864

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife VIRGINIA YOUNG

6.(c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) FEBRUARY 24, 1907

8. AGE: Years	Months	Days	If less than one day
40	5	25	hrs. min.

9. Birthplace MARYLAND, Rawlings
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Wright-Richardson Construct. Co.

FATHER
12. Name GEORGE WOLFORD
13. Birthplace MARYLAND

MOTHER
14. Maiden name RACHAEL MALONE
15. Birthplace W. Virginia

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 21, 1947 (month) (day) (year)

Cemetery or crematory Malone Cem.

Location Fort Ashby Rd. W.Va. near Cumberland, Md.

18. Funeral director H. Wayne George

Address Cumberland, Md.

19. Aug. 21, 1947 (Date rec'd by registrar) Winter L. Fraunfelter M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 19 1947 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 16 1947 to Aug 19 1947 and that I last saw him alive on Aug 19 1947

Immediate cause of death	DURATION
Renal Perforation	
Due to Perforated duodenal ulcer	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Perforated duodenal ulcer Date of op. 8/16/47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. E. Rogers M. D. or other

Address Cumberland Date signed 8/20/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M